GEORGIA STATE UNIVERSITY

Student Health Clinic & Student Counseling Center
Consent for Release of Health Information by Grady Hospital

Printed Name of GSU Student DOB: Panther ID #

By signing below, I authorize Grady Hospital to release my health information both verbally and in writing to Georgia State University Student Health Clinic and Student Counseling Center clinicians for the purpose of evaluation and/or continuing treatment regarding the following: my medical and/or psychiatric assessment, current condition, time of discharge (immediately upon discharge) and discharge summary, and/or transfer to another medical facility Georgia State University clinicians(s).

Signature of GSU Student DOB: Panther ID #